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2 **BEFORE THE ARIZONA MEDICAL BOARD**

3 In the Matter of

4 **TIMOTHY J. GELETY, M.D.**

5 Holder of License No. 21851
6 For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-05-0866A

**FINDINGS OF FACT,
CONCLUSIONS OF LAW AND ORDER**

(Letter of Reprimand)

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8 The Arizona Medical Board ("Board") considered this matter at its public meeting on
9 February 7, 2008 after the case was remanded from the Arizona Superior Court. The Board
10 voted to issue the following Findings of Fact, Conclusions of Law and Order ("Order") after due
11 consideration of the facts and law applicable to this matter. This Order replaces the previous
12 Findings of Fact, Conclusions of Law and Order issued by the Board on December 7, 2006.

13 **FINDINGS OF FACT**

14 1. The Board is the duly constituted authority for the regulation and control of the
15 practice of allopathic medicine in the State of Arizona.

16 2. Respondent is the holder of License No. 21851 for the practice of allopathic
17 medicine in the State of Arizona.

18 3. The Board initiated case number MD-05-0866A after being notified a hospital
19 suspended Respondent's privileges. A Board Medical Consultant subsequently reviewed medical
20 records involving certain of Respondent's patients.

21 4. On May 27, 2004 Respondent performed laparoscopic surgery on a twenty-eight
22 year-old female patient ("YS"). Post-operatively, YS complained of leg numbness. Anesthesia
23 evaluated YS and tried between 1500 and 2100, without success, to contact Respondent.
24 Anesthesia admitted YS for observation. YS's symptoms resolved and she was discharged on
25 May 28, 2004.

1 5. Respondent was not concerned about YS's symptoms because it is common for
2 there to be some numbness after surgery when the legs have been in stirrups. Respondent noted
3 even if YS had a nerve injury it was not an acute thing and there was nothing he could do about it
4 – she would have to see a neurologist. Respondent did not examine YS when he received the
5 report of numbness. Respondent was not on-call and at 5:00 when he left the clinic he shut off his
6 cell phone. Respondent did not know if it was clear to staff when he left the hospital that if YS had
7 further difficulties which physician they were to call. Respondent testified there was no acute
8 need for YS to be seen by a neurologist or a surgeon because there was no surgical complication
9 – her vital signs were stable and she was doing fine.

10 6. When Respondent is not on-call the hospital calls his "on-call" phone number and
11 his nurse practitioner will answer. Respondent was unclear as to whether the "on-call" phone his
12 nurse practitioner answers has the same phone number as his phone or whether there are two
13 on-call numbers. Respondent could only say he knew if the hospital could not contact him, it
14 would contact the nurse practitioner.

15 7. The standard of care required Respondent to be immediately available to evaluate
16 and treat post-operative complications unless he made other coverage arrangements.

17 8. Respondent deviated from the standard of care because he was not immediately
18 available following YS's surgery to evaluate and treat her post-operative complication and
19 because he did not make coverage arrangements.

20 9. Although YS's post-operative complication was mild, there was a potential for
21 more severe problems to present and significant complications could have ensued.

22 **CONCLUSIONS OF LAW**

23 1. The Arizona Medical Board possesses jurisdiction over the subject matter hereof
24 and over Respondent.

25 2. The Board has received substantial evidence supporting the Findings of Fact

1 described above and said findings constitute unprofessional conduct or other grounds for the
2 Board to take disciplinary action.

3 3. The conduct and circumstances described above constitutes unprofessional
4 conduct pursuant to 32-1401(27)(q) ("[a]ny conduct or practice which is or might be harmful or
5 dangerous to the health of the patient or the public").

6 **ORDER**

7 Based upon the foregoing Findings of Fact and Conclusions of Law,

8 IT IS HEREBY ORDERED:

9 Respondent is issued a Letter of Reprimand for not being available in a timely fashion to
10 evaluate a post-operative patient.

11 **RIGHT TO PETITION FOR REHEARING OR REVIEW**

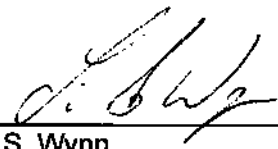
12 Respondent is hereby notified that he has the right to petition for a rehearing or review.
13 The petition for rehearing or review must be filed with the Board's Executive Director within thirty
14 (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review
15 must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103.
16 Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a
17 petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35)
18 days after it is mailed to Respondent.

19 Respondent is further notified that the filing of a motion for rehearing or review is required
20 to preserve any rights of appeal to the Superior Court.

21 DATED this 3rd day of April, 2008.

22 ARIZONA MEDICAL BOARD



By 
Lisa S. Wynn
Executive Director

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ORIGINAL of the foregoing filed this
30 day of April, 2008 with:

Arizona Medical Board
9545 East Doubletree Ranch Road
Scottsdale, Arizona 85258

Executed copy of the foregoing
mailed by U.S. Mail this
30 day of April, 2008, to:

Paul Giancola
Stephanie Hackett
Snell & Wilmer
One Arizona Center
400 E. Van Buren
Phoenix, Arizona 85004-2202

Timothy J. Gelety, M.D.
Address of Record

